association between the Symmetry and proximal graft failure. My concern is in the wider area of dissemination and adoption of new technologies. Without statements on data limitations, publication of biased noncomparative data on any new technology is potentially alarmist (or overoptimistic), may prevent proper evaluation and development, and may unnecessarily hinder (or accelerate) uptake of new technologies, some of which could be potentially beneficial (or harmful). Authors of reports on new technologies should list limitations and highlight any confounding factors or alternative explanations for adverse events (or benefits); otherwise readers could be inadvertently misinformed.

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Reply to the Editor:

I thank Mr Anyanwu for his interesting remarks.

I agree with the statement of Mr Anyanwu concerning the use of the internal thoracic arteries in coronary artery bypass grafting. I used to follow the same strategy and prefer extended utilization of the left internal thoracic artery as a graft especially, for the left anterior descending (LAD) and/or diagonal branches. We accept it as graft source irrespective of patient age, so that in about 92% to 95% of the patients the left internal thoracic artery is placed in the LAD area, although the average patient age is around 72 years old. I decided intentionally to make an exception to this strategy as I wanted to gain intensive experience with the new technology in creating the proximal vein graft anastomosis within a short period of time, so that mostly no internal thoracic arteries were used in the mentioned patient group unless the vein quality was inadequate.

Although in this series the first use of the anastomotic device took place on April 30, 2001, and the last one on October 22, 2001, of these 45 reported patients, 35 were operated on in the relatively short period of time from June 1 to July 5, 2001.

I agree that the calcified ascending aorta implies the utilization of the pedicled internal thoracic arteries. However, I often place many grafts in multimorbid octogenarians with more or less calcified ascending aortae, and I am forced to at least partial use of vein grafts. I try then to find the most suitable site for the proximal anastomosis, regardless whether the given anastomosis is hand-sewn in the conventional way or performed by use of any anastomotic device. I have never faced results like these until now. In very heavily calcified ascending aortae, both techniques are expected to fail; if at all possible the aorta should be replaced.

For the same reason of gaining experience with off-pump techniques within this period of time, accepted coronary patients were primarily declared for off-pump procedure without any preselection (ie, regardless of coronary morphology and other relevant factors).

I used to make the final decision to proceed or not with the off-pump technique at the very beginning of the surgery, making it dependent on the feasibility of this technique, so that many patients were switched to on-pump without making any effort to follow the off-pump strategy. I converted to on-pump quite liberally for 2 reasons. First, I am generally not convinced of the superiority of the off-pump techniques; second, I often face an extremely bad coronary morphology and/or bad ejection fraction. I mean the borderline cases in whom the feasibility of coronary artery bypass grafting is generally problematic. With those patients, we try to proceed with the conventional bypass surgery before we are forced to use any form of an end-stage therapy (ie, heart transplantation, implantation of an assist device for recovery, for bridging, or as definite surgery). Our heart center is a leader in utilizing mechanical circulatory support devices; we successfully follow this strategy in patients with end-stage coronary artery disease for a long time.

My article is a case report and not a randomized study; as such, you will find no comparison with any statistical significance. However, the causality between the utilized technology for creation of the proximals and the reported complication is in my opinion quite possible as these complications are an exceptional “on the row” phenomenon in my practice. I used to perform about 350 to 450 isolated coronary artery bypass grafting procedures each year; the operative capacity of the entire heart center is about 5000 cardiac procedures including approximately 3500 isolated coronary artery bypass grafting procedures yearly. My colleagues and I have never faced a similar experience. These were the first graft occlusions or stenoses that I had to deal with in many years.

I would like to use this opportunity to report an additional case of severe stenosis of the proximal vein graft anastomosis created with ACS. A 65-year-old man with 1 sequential vein graft to LAD and diagonal branch placed in off-pump technique using the ACS developed de novo angina pectoris 6 months after surgery. Angiography revealed a severe stenosis of the proximal anastomosis. Very impressive was the retrograde filling of the graft until the stenosed proximal anastomosis. The patient underwent successful redo surgery; I could not find any explanation for the event this time, either. However, I do not claim to deliver any evidence for or against the utilization of the device. I have highlighted in my article that the role of the device in the genesis of the reported complications has to be cleared.

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Pattern of lymphatic spread and prognosis in pN1 non–small cell lung cancer: What does it stand for?

To the Editor:

We read with great interest the report from Marra and colleagues[1] recently published in the *Journal*, and we warmly congratulate them on their excellent, accurate, and exhaustive analysis and report. They have confirmed that within the pathologic N1